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Timing of Ovarian Function Suppression in Premenopausal HR+ Early-Stage Breast Cancer

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Dr. Kaklamani:
This is CME on ReachMD. I'm Dr. Virginia Kaklamani.

Dr. Swain:
And I'm Dr. Sandra Swain.

Dr. Kaklamani:
So, Sandy, when should we initiate ovarian function suppression in premenopausal patients with HR-positive early-stage breast cancer?

Dr. Swain:
I think this is a really hard question for a lot of people. If the patient does get chemotherapy and you're using ovarian suppression for fertility protection, then you obviously start the ovarian suppression at the same time. You wouldn't start tamoxifen or the aromatase inhibitor with chemotherapy, however, it would just be the ovarian suppression. Now, if you want to wait, if you don't care about the fertility protection, you would give it after chemotherapy.And you can give the ovarian suppression and your aromatase inhibitor, tamoxifen, during radiation therapy.

So, as far as the other issues with timing of the ovarian suppression, in the TEXT trial, they gave it at the same time as if the patient was going to get chemotherapy, whereas in the SOFT trial they started it after, only if the patient had chemical estradiol that was indicative of a premenopausal status. So, those patients were clearly premenopausal so there was a big difference in the two trials.

So, as I was saying, I would time it to give it after chemotherapy and if you are concerned that the patient's not premenopausal, you could measure estradiol. I routinely don't do that because they can actually get their ovarian function back, even if they are postmenopausal immediately after chemotherapy. So, I would start the ovarian suppression after the chemotherapy with the aromatase inhibitor, and it can be done at the same time because ovarian suppression is very quick. The estradiol drops very quickly in the first couple of weeks.

Dr. Kaklamani:
And so, here's where I typically differentiate based on the patient's age. We know that if somebody's younger than 45 or so, there's a pretty good chance that with chemotherapy, they'll still maintain their ovarian function. You're going to have to do ovarian suppression, and so in those patients, I'm very likely to give OFS after the chemotherapy and without measuring any estradiol levels.

Now, if somebody's in their late 40s or early 50s, but were still premenopausal before I started therapy, I kind of know that the chance of them maintaining their premenopausal status is pretty low, so I don't want to subject them to ovarian suppression for 5 or 10 years. So,

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in that case what I typically do is, I'll initiate tamoxifen, and I'll measure estradiol levels and I probably will do that for a year because as you mentioned, there's a pretty good chance of regaining function later on.

And then, if I if those patients continue to be post menopausal, I will switch them to the AI without OFS. If I see that they're premenopausal, I'll give them the ovarian suppression.

Dr. Swain:
No, I think that's really a good point. I had a patient once that was 52 and I thought for sure she would not regain function, so I put her on aromatase inhibitor which was absolutely the wrong thing to do because her menses resumed.So, I totally agree with your approach there. I would do it exactly the same way.

And if you actually look at the recent data from the RxPONDER trial, you could also measure an AMH level which will tell you what kind of ovarian reserve is remaining. And then, in those studies, if the AMH level was low, then they didn't get a benefit from chemotherapy, for example. But we're talking about ovarian suppression here, but they probably wouldn't, also, get a benefit from ovarian suppression.

Dr. Kaklamani:
I think that that's a great point, and that data was actually very provocative. And I hope our fertility colleagues use AMH all the time to measure with the chance of pregnancies and so forth. And we, I think, underuse it in breast cancer. But this is a great measure of – ovarian reserve that I think is exactly what we're trying to do here.

So, I think, Sandy, it's an extremely important point that these women that are premenopausal and continue to be premenopausal after chemotherapy, they have a significant benefit from OFS, and so making sure that they do receive OFS, or at least discussion on OFS, is extremely important here.

So, this is all the time that we have today. I want to thank Dr. Swain for this wonderful discussion and thank you to the audience for listening in.

Announcer:
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